



DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)  
ADULT FAMILY HOME (AFH)

**AFH QUALITY IMPROVEMENT VISIT  
ASSESSMENT**

DD PQI RESOURCE MANAGER	
DATE OF VISIT	TIME OF VISIT
<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	

FACILITY'S NAME				PROVIDER'S NAME		
STREET ADDRESS				MAILING ADDRESS (IF DIFFERENT FROM AFH)		
CITY		ZIP CODE		CITY		ZIP CODE
TELEPHONE NUMBER		FAX NUMBER		CELL PHONE NUMBER		E-MAIL ADDRESS
LICENSE NUMBER	SSPS PROVIDER NUMBER		DSHS AFH LICENSED CAPACITY		DSHS AFH CONTRACT EXPIRATION DATE	
<b>* ASTERISK THOSE RESIDENTS PRESENT DURING VISIT</b>						
NAME OF DDD RESIDENT	DATE OF BIRTH	CRM	WAIVER STATUS	DAILY RATE	EVACUATION LEVEL	DD NUMBER
REASON FOR VISIT						
NAME OF STAFF OBSERVED OR INTERVIEWED DURING THE VISIT						
OTHER NON-RESIDENTS LIVING IN THE HOME						
POSITIVE COMMENTS REGARDING HOUSEHOLD INFORMATION						
ISSUES/CONCERNS						

IF NEW RESIDENT(S), REASON FOR MOVE	
NEGOTIATED CARE PLANS: <input type="checkbox"/> Current <input type="checkbox"/> Not Current – Explain:	
CARE ASSESSMENTS: <input type="checkbox"/> Current <input type="checkbox"/> Not Current – Explain:	
<b>COMPETENCE</b>	
COMMENTS/CONCERNS	
<b>HEALTH AND SAFETY</b>	
COMMENTS/CONCERNS	
<b>INTEGRATION</b>	
COMMENTS/CONCERNS	
<b>RELATIONSHIPS</b>	
COMMENTS/CONCERNS	
<b>POWER AND CHOICE</b>	
COMMENTS/CONCERNS	
<b>STATUS</b>	
COMMENTS/CONCERNS	
CASE RESOURCE MANAGER CONTACT	<input type="checkbox"/> SER Completed